Date Filed:	
File No.	

## STATEMENT OF CLAIM TO TRUSTEES OF THE LAWYERS' FUND FOR CLIENT PROTECTION OF THE SUPREME COURT OF DELAWARE

## **INSTRUCTIONS**

- Answer every question. If space is inadequate, attach additional pages.
- You must submit copies of canceled checks, receipts, letters, etc. that will support your claim.
- Your claim must be notarized.
- Mail your completed claim to: Bunny Christopher, Executive Director, Lawyers' Fund for Client Protection, 820 N. French Street, 11<sup>th</sup> Floor, Wilmington, DE 19801.

1.	Your Name:	
2.	Your Address: (street)	
	(city, State, zip code)	-
3.	Your Daytime Telephone Number:	_
4.	Name of lawyer being complained about:	_
5.	Address of that lawyer:	_
6.	How much money do you claim you lost?	-
7.	State the date the loss occurred:	_
8.	State the date when you discovered the loss:	
9.	What do you claim the lawyer did wrong?	

Name:	Name:
Address:	Address:
Tel. No.:	Tel. No.:
	you claim to have lost? If so, state recovered it and from whom you recovered it.
with respect to the money you claim so, state the name of the lawsuit, the	l a judgment against the lawyer or anyone else to have lost? If date it was filed, the court in which it was filed.
and the date of the judgment, if any.	
3. Are you personally related to the lawy	yer being complained about or are you/were you hat lawyer? If so, er.

NOTE: No lawyer is permitted to charge you a fee for assisting in the preparation or resolution of this claim.

NOTICE TO CLAIMANT: By signing this claim form, you indicate that you understand that the Lawyers' Fund for Client Protection has no legal responsibility for the acts of individual lawyers in their practice of law, that the decision of the Trustees of the Lawyers' Fund for Client Protection to pay anything to you on account of your claim is entirely within their own judgment and is not a matter of your right, and that neither you nor anyone else has the right to sue the lawyers' Fund for Client Protection or its Trustees on account of your claim.

STATE OF DELAWARE	∃ :			
	:	SS	<u>AFFIDAVIT</u>	
COUNTY OF	:			
		0 <b>1110</b> 0#0	under eath (or offices) that (a)ha	:.
the person who has the cl	aim described it		under oath (or affirms) that (s)he nent of Claim, that (s)he has read a	
•			nat the information contained in the	
			own knowledge, that (s)he agrees	
			lso in any disciplinary proceedin	
against the lawyer compl	ained about, an	d that if the	Trustees decide on any payment	oi
this claim, (s)he agrees to	sign any appro	priate docun	nents that the Trustees may require	•
		(Signat	ure of Claimant)	-
		(Signat	ure of Claimant)	
Signed and sworn to (c	or affirmed) before	ore me on		
· ·	,			
	by			_
(Date)		(Name o	of Claimant)	
		(Cianat	una of Notorial Officer)	
		(Signat	ure of Notarial Officer)	
		(Title o	f Notarial Officer)	
		,	,	
		My con	nmission expires	